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Health Services or Sins: A Qualitative Study of American Millennial Catholics' Attitudes toward Hormonal Contraception and Abortion

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Chapter 1 - Introduction

Contemporary Contraception and Abortion Service Use

Contraception and abortion are two aspects of women's health that are well-researched, with contraception being used at high rates among women in the US for pregnancy prevention as well as medical reasons. Uses for contraception and reasons for seeking abortion services vary. In the US, 88.2% of women have used contraception at some point in their lifetime and by the age of 30 and 19% of women have obtained an abortion. (Daniels et al., 2013; Jones and Jerman, 2017). Among women who obtained abortions in 2015, 58.7% were women in the millennial cohort, ranging from ages 22-38 (Pew Research Center, 2017; Jatlaoui et al., 2018).

Since the 1960's, there has been significant social change leading to a shift towards increased reproductive rights for women and sex positivity in the United Sates (US). In 1960, the birth control pill was approved by the FDA, allowing women to have effective control over their fertility for the first time (Boston Women's Health Book Collective, 2011). However, in order to be prescribed birth control, a physician had to diagnose women as having a menstrual disorder. In 1965, birth control was fully legalized for married couples through Griswold v. Connecticut. Finally, in 1972, Eisenstadt v. Baird legalized birth control for all women as a family planning tool. Meanwhile, on the abortion front, the landmark case of Roe v. Wade had legalized abortion in the first trimester, citing it as a woman's "right of privacy… founded in the 14th Amendment's concept of personal liberty" (Boston Women's Health Book Collective, 2011). Three years later, Congress passed the Hyde Amendment, which effectively banned federal funding of abortion excluding cases of rape and incest (Boston Women's Health Book Collective, 2011). Since the 1970's there have been a myriad of other legislative developments in regards to contraception and abortion. However, one highly impactful change came in March 2010 with the Affordable Care

Act (ACA). The ACA mandated that insurance companies cover the cost of birth control insofar that there is no out-of-pocket cost for women (Hemlin, 2017). This mandate changed the stage for the uptake of contraception both financially and socially. Previously, birth control averaged $90 per month for women, creating a significant financial barrier for 55% of women, who reported non-use of birth control due to cost (Hemlin, 2017). No-cost birth control availability added a sense of social urgency to its uptake, as some groups of sexually active women now view its use as an obligatory act of responsibility in sexual and reproductive health (Hemlin, 2017).

While health insurance coverage of contraception is nationally mandated and there are no legal restrictions on contraception, the story is vastly different for abortion; health insurance coverage of abortion services are not required and the legality of abortion and procedures to procure an abortion are determined on a state level (Hemlin, 2017; Guttmacher Institute, 2019). With the Hyde Amendment still in place, states are allowed to allocate their own public funds to abortions, but may not allocate any federal funds to abortions (Boston Women's Health Book Collective, 2011). As of February 2019, 16 states use their own revenues to fund abortions for Medicaid enrollees in any case, while 33 states and the District of Columbia only allow use of state funds insofar as federal funds are allowed to be allocated: in cases where the woman's life is in danger or the pregnancy is the result of rape or incest (Guttmacher Institute, 2019). Among states, abortion laws are greatly varied and may include several stipulations about laws including: physician and hospital requirements, waiting periods, gestational limits, private insurance, provider refusal, state-mandated counseling, and parental involvement. Among the most common abortion laws are provider refusal, physician requirements, and gestational limits. Currently, 45 states allow providers to refuse to conduct an abortion, 43 states impose gestational limits on abortion, and 42 states require that abortions be performed by a licensed physician (Guttmacher

Institute, 2019). Among states with gestational limits, 19 states prohibit abortion after 20 weeks, 6 states prohibit abortion after 24 weeks, 1 state prohibits abortion in the 3rd trimester, and 17 states prohibit abortion after it is decided that the fetus is viable (Guttmacher Institute, 2019). These laws prohibit abortion except in the case of maternal endangerment. Of course, while Roe v. Wade allows for abortion in the first trimester, states have the ability to formulate their own laws around abortion as well.

While the US holds the ideal of separation of church and state, "social and political values are codified through the legislative process," meaning that religiously-based ideas about contraception and abortion have the potential to be enacted through policy (Calfano, 2006). Approximately 22% of millennials, people ages 22-38, identify as Catholic, with millennial Catholics accounting for approximately 4.6% of the total population; this gives their opinions a fair amount of weight in respect to voting (Bedford, 2012; Pew Research Center, 2017; US Census Bureau, 2017; Feldmann et al., 2016). Thus, their opinions may have implications on sexual and reproductive health policy. Among all age groups, abortion, more so than contraception, is a highly controversial issue. Further, abortion has demonstrated the ability to lead some citizens to reconsider their partisanship, as the Democratic party is generally more liberal concerning sexual and reproductive health issues, including abortion and contraception (Adams, 1997; Jelen and Wilcox, 2003; Hoffman and Johnson, 2005). Previous research investigates the impact of religion on attitudes surrounding contraception and abortion, but does not do so among this cohort in specific.

Despite a societal shift towards liberal reproductive health laws and sex positivity in the western world, Church officials continue to stand strongly in opposition of contraception and abortion. In the 2012 election year, 72% of Catholic Church bulletins had political underpinnings,

and 38% had direct pro-life messages (Holman and Shockley, 2017). Pro-life messages included rhetoric about abortion, the right to life, 40 days for life, and adoption (Holman and Shockley, 2017). Contrary to the Church's opinion on contraception, recent data from the Guttmacher Institute indicates that Catholic women obtain abortions at nearly the same rate as all women and that Catholic women at risk of unintended pregnancy use both hormonal and barrier methods of contraception at the same rate as all women (Jerman, Jones, and Onda, 2016; Jones and Dreweke, 2011). Results from a 2016 study funded by the nonprofit organization, Catholics for Choice, found that 79% of Catholics believe birth control should be covered by insurance (without indication of whether this insurance should be public or private) and 60% believe that the decision to have an abortion "can be a morally acceptable position" (Catholics for Choice, 2016). However, the sample for this study was only comprised of 17% millennials, which is not representative of the actual age distribution of the current Catholic population in the US.

This study investigates American millennial Catholics' opinions about contraception and abortion as well as the factors that are involved in their opinion-formation, and considers the sociopolitical implications of said opinions. Specifically, the study aims to understand the relationship between identifying as Catholic and attitudes towards contraception and abortion among American millennials. Due to the formative nature of this study and its goals to investigate social phenomenon and "the complexity of human beings and their lives," qualitative research methods are most appropriate (Sterk and Elifson, 2004). The researcher used a thematic analysis approach in order to conduct textual analysis of twenty-one semi-structured interviews among both male and female American millennials who were raised Catholic and currently identify as Catholic (Braun and Clarke, 2006).

Theoretical Framework

The Theory of Triadic Influence (TTI) and the Moral Foundations Theory (MFT) provide a holistic and ecological approach to understanding the ways in which Catholics form their opinions about abortion and contraception, as well as how these opinions are transformed and/or solidified over time. According to TTI, levels of causation and streams of influence exist, creating a matrix of influential sources at different levels, which impact attitudes, perception, and behaviors (Flay, Snyder, and Petraitis, 2009). Levels of causation range from proximal to distal and streams of influence include intra-personal influences, interpersonal social influences, and cultural-environmental influences. While intra-personal influences are particularly important in determining whether American millennial Catholics will utilize contraception or seek abortion services themselves, interpersonal social influences and cultural-environmental influences have a larger impact on how acceptable American millennial Catholics deem contraception and abortion for others (Flay, Snyder, and Petraitis, 2009).

In addition to the TTI, MFT provides a framework for understanding religion as the moral foundation for interpersonal social influences. MFT includes five domains for moral judgement formation: (1) care/harm, (2) fairness/cheating, (3) loyalty/betrayal, (4) authority/subversion, and (5) sanctity/degradation. Further, according to MFT, there are four basic tenets of moral foundation: (1) we are all born with a "first draft" of the moral mind, (2) this first draft is edited within a particular culture, (3) intuition and judgement precedes strategic reasoning, meaning that we come to conclusions before we think critically about how we can justify those judgements, and (4) we encounter recurrent social challenges that transform and solidify our morality (Graham et al., 2012). The five moral domains are transformed through each of the basic tenets of moral foundation. Thus, MFT exists within the interpersonal social influence stream as the way in which

the Catholic microcosm informs socio-normative beliefs about contraception and abortion before they are challenged by broader cultural-environmental influences.

Purpose and Aims

This study serves to investigate American millennial Catholics' opinions about contraception and abortion as well as the factors that are involved in their formation and their sociopolitical implications.

- To describe the opinions about contraception and abortion among American millennial Catholics.
- To identify and describe the factors that shape how American millennial Catholics view the interface of religion and sexual and reproductive health policy.

Chapter 2 – Literature Review

To form a foundational understanding of the status of contraception and abortion in the United States (US) and to understand how external influences such as religion intersect with reproductive health, this chapter will review key topics regarding hormonal contraception and abortion. Specifically, the chapter will address the following: the current utilization of a legislation about contraception and abortion in the US, religious aspects of contraception and abortion, the stance of the Roman Catholic Church on contraception and abortion, ways in which the Church promotes it's ideology about contraception and abortion, and a proposed theoretical framework for how American Millennial Catholics form their attitudes towards contraception and abortion.

Contraception and Abortion in the US

Currently, contraception laws in the US are much more permissive than abortion laws. The ACA mandates that health insurance policies cover contraception, including coverage by Medicaid. The federal government does not require that abortion services be covered by healthcare insurance and does not participate in the direct federal funding of any abortion services (though all states do participate in state funding of abortions to save the life of the mother, as well as in cases of rape and incest) (Hemlin, 2017; Guttmacher Institute, 2017). Further, while contraception and abortion are both legal in all states, states have individual laws regarding abortion procurement procedures. However controversial abortion may be, state policies tend to align with residents' opinions about abortion; in general, states in which the majority of residents believe that abortion should be "illegal in all or most cases" have stricter abortion laws, while states in which the majority of residents believe that abortion should be "legal in all or most cases" allow for easier access to abortions (Pew Reseach Center, 2014; Guttmacher Institute, 2017). For example, while Colorado has no restrictions on abortion, abortion is heavily restricted in Mississippi (Guttmacher

Institute, 2017). Women who intend to procure an abortion in Mississippi must do so before 15 weeks of gestation, may only get an abortion from a licensed obstetric gynecologist, must receive counseling, must view an ultrasound of their pregnancy during the consultation, and must wait 24 hours between their counseling session and getting the abortion procedure (Guttmacher Institute, 2017). These states have vastly different abortion laws; however, their residents also hold differing opinions: while 59% of Coloradans believe that abortion should be "legal in all or most cases," 59% of Mississippians believe that it should be "illegal in all or most cases" (Pew Research Center, 2014).

In assessing Catholic attitudes towards contraception and abortion, it is important to consider the overall landscape of contraception and abortion service utilization throughout the US in order to understand the overall cultural environment surrounding both contraception and abortion. In the United States, Catholics do not utilize contraception or obtain abortions at a significantly different rate than people of other religions or of no religious-affiliation (Jones and Dreweke, 2011; Jerman, Jones, and Onda, 2016).

Contraception

In the United States, 88.2% of all women ages 15-44 have used contraception at some point in their life, with the rate raising to 99.1% among sexually experienced women (Daniels et al., 2013). Further, women in the cohort have tried, on average, 3.1 different methods of contraception. White women are slightly more likely to use contraception than both Hispanic women and black women, with utilization rates at 66%, 60%, and 54%, respectively (Jones et al., 2012). Variance on contraception utilization by religion is minimal (Jones and Dreweke, 2011). The most common forms of contraception include hormonal pills, followed by female sterilization, male condoms, and long-acting reversible contraceptives (LARCs) (Daniels et al., 2015; Kavanaugh and Jerman,

2018). Only approximately 2.2% of women use the family planning method promoted by the Catholic Church: natural family planning (Pavuk, 2016; Mulligan, 2015; Kavanaugh and Jerman, 2018). Natural family planning, also known as the rhythm method, encourages couples to engage in sexual intercourse only when the women is not ovulating (Mulligan, 2015). Social contacts' experiences, the contraception-related experiences shared with women by other women in their social network, are the strongest predictor of contraception utilization and method choice (Cohen et al., 2017).

Among women, conversations about contraception are initiated most often by themselves (55%), followed those initiated by a clinician (27%) (Nelson et al., 2018). The remainder of conversations were initiated by a family member (11%). While many women (49%) express concerns about possible side effects associated with contraception, they still decide to initiate contraception utilization. Control of menstrual bleeding is a primary reason for contraception initiation, and many women cite contraception as a facilitator in allowing them to take better care of themselves, support themselves financially, complete their education, and/or find career stability (Frost and Lindberg, 2013; Judge et al., 2017). Overall, most women value contraception as a tool that allows them to gain autonomy over their lives and their bodies.

Abortion

Between 2011 and 2014, the number of clinics offering abortion declined by 6% nationwide, with the largest decline occurring in the Midwest (22%) and the South (13%). In 2014, nearly 20% of pregnancies in the US ended in an abortion, resulting in 926,200 abortions (Finer and Zolna, 2016; Jones et al., 2018). This is the lowest abortion rate since abortion was legalized in 1973, representing a 14% decline over three decades (Jones and Jerman, 2017). Among women who reported having an abortion in 2014, 45% have had at least one previous abortion (Finer and

Zolna, 2016; Jones et al., 2018). White women account for the majority (39%), followed by black women (28%), Hispanic women (25%), and Asian women (6%) (Jerman et al., 2016). According to the CDC, in 2015, 58.7% of abortions were obtained by women in the millennial cohort (Jatlaoui et al., 2018). Overall, 62% of women obtaining an abortion had some sort of religious affiliation, with no significant difference in abortion rates between religious affiliations (Jones and Dreweke, 2011).

There is little previous qualitative research exploring pro-life women's attitudes towards abortion. Among women who had an abortion in 2004, responsibility to others, financial instability, and lack of social support were the most-cited reasons for abortion (Finer et al., 2005). Additional reasons included pregnancy as a product of rape, significant other or parents encouraging the abortion, completion of childbearing, and partner abuse, among others. Many pro-choice women see abortion as a sort of medical safeguard in case contraception fails; a medical safeguard that they have the human right to access (Judge et al., 2017). The most common reasons for abortion included that a child would inhibit the woman from continuing her education or advancing in her career path (74%), inability to afford the child (73%), and unstable or single relationship status with low self-efficacy for child care (48%) (Finer et al., 2005). Further, nearly 40% of women obtaining abortions expressed that they did not want any more children and about 33% expressed that they were not yet ready for children.

Gendered Attitudes

When considering both abortion and contraception, it is plausible to think that men and women might hold different attitudes, likely due to the lesser degree to which abortion and contraception directly impact men. Men and women's distinct positionalities inspire varying attitudes and justifications of these attitudes. Previous research shows that while contraception and

abortion are framed as women's health issues, rather than general sexual and reproductive health issues, women are no more likely than men to support contraception and abortion (Carlton et al., 2000; Patel and Johns, 2009; Hertel and Russell, 1999). However, a more recent study by Loll and Hall (2018) exploring abortion attitudes among 69,901 participants from 51 different countries found that women do tend to have more supporting attitudes towards abortion than men. Additionally, while there is conflicting evidence as to whether men and women have significantly different attitudes, women do consider the issues of contraception and abortion to be more important than men do and tend to have more well-defined and substantiated opinions (Hertel and Russell, 1999).

There is little previous qualitative research on the attitudes of men in regards to contraception or abortion. However, this points to a larger problem in American society: men are not generally participants in conversations regarding sexual and reproductive health. According to a study by Merkh et al. (2009), men's understanding of hormonal contraception varies greatly based upon sexual experiences, age, and relationship type, with men in committed relationships having the greatest understanding of contraception. Further, men tend to play a key role in contraception utilization negotiation, highlighting the importance of male-understanding of contraception in order for couples to engage in informed decision-making processes (Smith et al., 2011; Merkh et al., 2009). However, while men play a critical role in contraception decision-making processes both actively and passively, they also demonstrate beliefs of low personal responsibility for pregnancy prevention, disincentivizing them from learning about contraception (Smith et al., 2011). Thus, although men unwittingly play a large role in contraception utilization negotiation, they are not largely motivated to learn about contraception because they are unaware of the role they play in contraception decision-making. This is likely contributed to by the fact that

boys are often excluded from sexual and reproductive health conversations throughout adolescence (Ekstrand et al., 2007; Tolman et al., 2003). Nonetheless, men's attitudes about sexual and reproductive health have a direct impact on women's sexual and reproductive health decisions, as well as the availability of sexual and reproductive health resources.

Religious Aspects of Contraception and Abortion

Both abortion and contraception elicit reactions from religious institutions, largely due to their proximity to theology about the creation of life. Evangelists, Southern Baptists, Catholics, and Muslims, in addition to smaller religions such as Mormons, take issue with abortion on an institutional level because they assert that life begins upon conception; thus, abortion is seen as ending a life (Hoffman and Johnson, 2005; Christopher, 2006). Religious teachings regarding abortion are rather unwavering because they are centered around ideology about when life begins, meaning that teachings about abortion are rooted in some of the most central teachings in religion (Hoffman and Johnson, 2005). Further, the nature of religious groups and their tendency towards continuation of religious tradition through the passing of religious traditions to children elicit expectations about fertility and fertility control (Christopher, 2006). While religious institutions are typically clear about their expectations regarding sexuality and fertility, there are varying degrees of religious observance of these expectations.

Previous research has found that religiosity, measured by frequency of religious participation, is negatively associated with sexual and reproductive service use among young women aged 15-24 (Jones et al., 2005; Hall et al., 2012; Patton et al., 2015). Specifically, regardless of sexual experience, women who displayed less-than-weekly religious community participation were 50% more likely to use sexual and reproductive health services, including services for contraception, sexually transmitted infection testing or treatment, and yearly

gynecologic examination (Hall et al., 2012). In addition, a study of undergraduate students by Martin et al. (2017) found that higher rates of religious attendance are associated with lower levels sexual and reproductive health knowledge. There is conflicting data on whether religiosity is associated with contraception utilization; some studies find that religiosity is associated with decreased contraception utilization, while others find that contraception utilization is not significantly different across religious groups (Kramer et al., 2007; Hall et al., 2012; Hill et al., 2014; Jones and Dreweke, 2011). These discrepancies may be due to the ways in which study protocols define and measure religiosity and how religiosity is displayed across religious groups.

While religious affiliation impacts what people are taught about abortion, approval of abortion is more highly impacted by level of religious engagement than it is by the religion with which a person identifies (Bartkowski et al., 2012; Jelen and Wilcox, 2003). A study by Adamczyk and Valdimarsdottir (2018) explored the association between county religiosity, the overall religious engagement of a county's population, and attitudes towards abortion and the availability of abortion services. In regards to abortion, as religiosity increases, both religious and non-religious residents display more conservative attitudes (Adamczyk and Valdimarsdottir, 2018). This can be explained by the fact that religious affiliation, belief, and engagement are important factors in shaping the overall public opinion about abortion (Jelen and Wilcox, 2003; Hess and Rueb, 2005). Further, a county's overall religiosity shapes the likelihood that the county has an abortion clinic, meaning that religion not only shapes beliefs about abortion, but it also has an indirect impact on access to abortion services (Adamczyk and Valdimarsdottir, 2018).

The Catholic Perception

Since its inception, the Roman Catholic Church has acted as a religious governance, asserting that "nothing unnatural should be involved in the process of life and/or its creation"

(Pavuk, 2016). However, technological advances in health sciences have consistently challenged this assertion. While the Church tends to make exceptions to allow for technology to aid in conception, two technological advances are heavily contested by the Roman Catholic Church: contraception and abortion. The rhythm method, which involves tracking the menstrual cycle of women to avoid sexual intercourse during the period in which they are most fertile, is the only contraception method endorsed by the Catholic Church (Pavuk, 2016). However, the rhythm method is not as effective in preventing pregnancy (Pavuk, 2016; Mulligan, 2015).

In spite of the Catholic institution's disdain for abortion, most Catholics will support the decision to procure an abortion in some circumstances (Catholics for Choice, 2016; Kung et al., 2018). One study of Mexican Catholics found that 90% of participants would support an abortion in the case of rape and/or endangerment of the mother's life (Kung et al., 2018). Further, 51% of participants believed that a women who has an abortion can continue to be a "good Catholic" (Kung et al., 2018). The range of attitudes towards abortion and contraception among Catholics may be due to the fact that there is only one Catholic church; if a person disagrees with an aspect of the religion, they do not have the liberty to simply switch parishes (Adamczyk and Valdimarsdottir, 2018). Specifically, other religious traditions, such as Protestantism, do not have a central governing body. Thus, if a member of a congregation disagrees with something that is being taught in a specific parish, they are free to find another parish that promotes different ideas. However, every Catholic church follows the same agenda set by the Papacy, meaning that while priests may explain things in different ways, they're generally promoting the same ideas that are disseminated to them by the Vatican. This may lead to an identifiably wider range of opinions within Catholic congregations; since the Catholic church generally promotes the same ideas across

all of its churches people generally pick their congregation based on location, rather than based on the content of the sermon (Adamczyk and Valdimarsdottir, 2018).

Theoretical Basis

Given the nature of qualitative research and the goal to understand opinion-formation, a theory-driven approach to understanding American millennial Catholics' opinions about hormonal contraception and abortion is warranted. A combination of the TTI and the MFT best enable the understanding of the intricate way in which being raised in a Catholic household can influence the moral schema of American millennials regarding hormonal contraception and abortion.

According to the TTI, intra-personal influences include intrapersonal characteristics that contribute to a person's the utilization of contraception and abortion (Flay, Snyder, and Petraitis, 2009). These influences can include self-efficacy, self-esteem, and personality. In regards to the utilization of contraception and abortion, intra-personal influences are most applicable to Catholics' intentions of ever using contraception or obtaining an abortion for themselves. Interpersonal social influences include the socio-contextual micro-environmental influences that contribute to social normative beliefs about abortion and contraception (Flay, Snyder, and Petraitis, 2009). Belonging to the Catholic community can be identified as an interpersonal social influence, as Catholics exist within the Catholic microcosm as well as within a larger socio-environmental context.

Within the TTI matrix, MFT can most appropriately be identified as a distal interpersonal social influence, as it relies on social normative beliefs and involves the social context that forms these beliefs about abortion and contraception (Flay et al., 2009; Graham et al., 2012). Figure 1 shows how MFT maps onto TTI. Catholics' beliefs can be well-mapped onto MFT, which is often used to understand religiously and morally-based attitudes and behaviors. According to MFT, there

are four basic tenets of moral foundation: (1) we are all born with a "first draft" of the moral mind, (2) this first draft is edited within a particular culture, (3) intuition and judgement precedes strategic reasoning, meaning that we come to conclusions before we think critically about how we can justify those judgements, and (4) we encounter recurrent social challenges that transform and solidify our morality (Graham et al., 2012). Thus, MFT exists within the interpersonal social influence stream as the way in which the Catholic microcosm informs social normative beliefs of American millennial Catholics about contraception and abortion before they are challenged by cultural-environmental influences. Cultural-environmental influences include macro-level environmental factors that contribute to attitudes towards contraception and abortion. Cultural-environmental influences can include political climate, socioeconomic status, and cultural identity beyond religion (Flay, Snyder, and Petraitis, 2009). These influences can also include education as an increase in socioeconomic status, which often challenges, transforms, and solidifies attitudes forwards contraception and abortion.

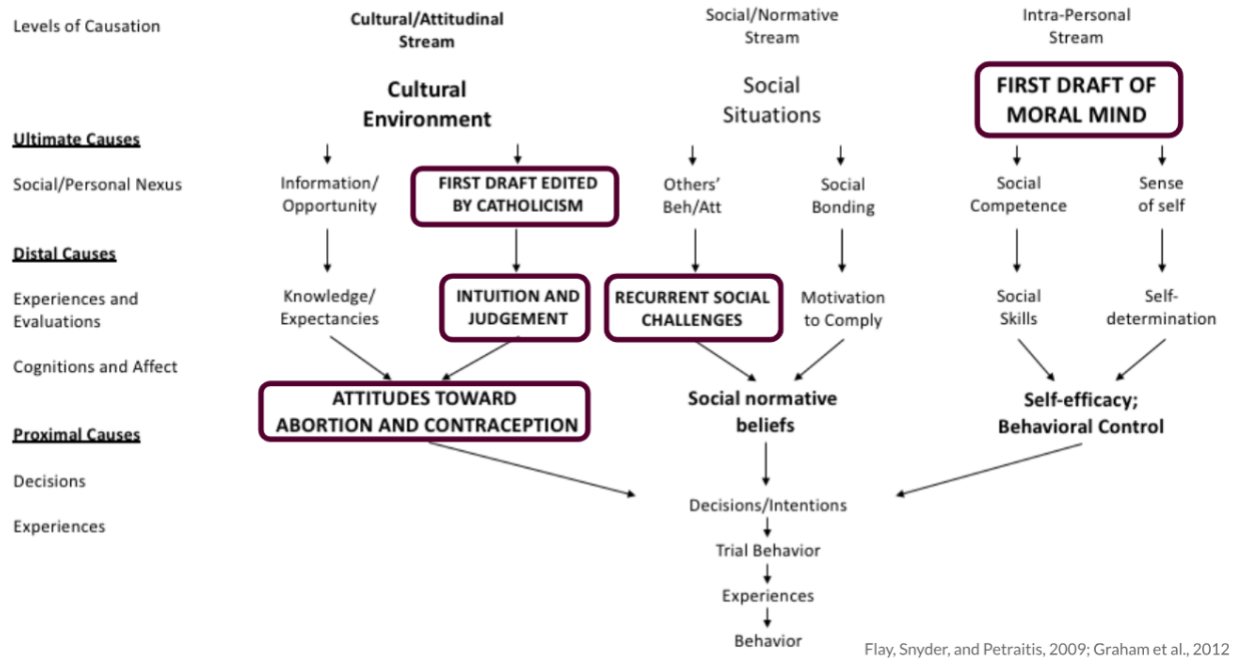

Figure 1. The figure depicts a simplified version of the Theory of Triadic Influence with constructs of the Moral Foundations Theory mapped into the appropriate places.

Thus, TTI provides an overall schema for the ways in which American millennial Catholics attitudes towards contraception and abortion, both for themselves and for others, are created and upheld, while MFT provides insight into the particular importance of Catholic upbringing as an initial moral basis. With TTI and MFT in mind, this study aims to identify and describe the mechanisms of Catholicism as a moral foundation, as well as the additional influences on attitude formation and transformation from the larger intrapersonal, interpersonal social, and cultural-environmental influence streams.

This study will provide data to fill the gap in research surrounding millennial Catholic attitudes about abortion and contraception by addressing opinion formation and conceptualization of contraception and abortion in order to understand American millennial Catholic adherence to Roman Catholic doctrine. Public health research largely focuses on identifying risk factors for diseases and health outcomes; however, investigation of cultural and ideological underpinnings of attitudes about health-related topics are important because of the impact they have on health policy, which in turn impacts disease and health outcomes. Understanding the ways in which populations are likely to vote or topics they're likely to advocate for can provide insight into how public health officials can effectively target interventions to promote positive health outcomes. This study in particular will provide insight into Catholic millennial attitudes about abortion and contraception. This will allow public health officials to uncover whether millennial Catholics might be a population that can be used to advocate for reproductive health in the larger Catholics population, which is generally opposed to unnatural interference in reproduction.

Chapter 3 – Methods

Project Conceptualization and Student Contributions

The project was originally conceptualized as a mini-study for the Behavioral Sciences and Health Education foundational course Qualitative Research Methods. The PI conceptualized the project while reflecting on her own positionality; as an American millennial Catholic with interest in both maternal and child health and sexual and reproductive health, the PI noticed a gap in the literature surrounding the attitudes of fellow American millennial Catholics about abortion and contraception. The PI was particularly interested in the topic due to the current contentious political landscape concerning sexual and reproductive health. The PI developed the protocol, designed data collection instruments, conducted all analysis, and drafted the manuscript for this study. The intended journal for first submission is *Religion and Health.*

Study Design

Recruitment and Informed Consent

The study was conducted by a Masters of Public Health student in the Department of Behavioral Science and Health Education for a thesis as her required integrative learning experience. For the purposes of this qualitative inquiry, a mixed-methods study design was used to gain a more clear and concrete grasp on conflicting and often quite complicated participant opinions. To accomplish this, semi-structured interviews were followed by a brief survey that included statements similar to those in the interview to be rated on a Likert Scale from "strongly disagree" to "strongly agree."

The study employed qualitative semi-structured interviews in order to "capture the complexities of human beings and their lives" (Sterk and Elifson, 2004). Interviews were conducted either in person or virtually, either via phone calls or Skype. Gate keepers, snowball

sampling, and purposive sampling were used to recruit participants. The PI used her Catholic in-group status to identify Catholic acquaintances and congregation members as gate keepers, who were asked to inform any potential participants about the study and pass along the PI's contact information. Following interviews, the PI asked participants if they knew of anybody who might be interested in participating in the study. Participants were given the PI's contact information to share with other potential participants, thus employing snowball sampling. Finally, the PI solicited participants from social media groups she identified as potentially reaching millennial Catholics. Piktochart was used to create an ad for the study (Appendix A). The ad provided details about time commitment and eligibility criteria and directed potential subjects to show interest by emailing the PI at her Emory University email address.

To be eligible, participants must qualify as millennials (having been born between 1980 and 1996), must have grown up and currently live in the United States, and must currently identify as Catholic. Potential participants were excluded if they converted to Catholicism. Potential participants were asked if they were raised Catholic or converted to Catholicism for screening purposes, in order to assess whether or not they were eligible to participate in the study. Upon enrollment, participants were asked to provide their name, phone number, and email address. All participants were assigned a pseudonym at the time of their enrollment. The study aimed to include 30 participants, but only 21 qualifying interviews were ultimately conducted due to the fact that saturation was reached before the initial goal of 30 interviews was met.

Informed consent was obtained from all participants prior to data collection. The link to an electronic consent form was emailed to each participant prior to the interview process. Both in person and virtually, participants had time to read the consent form (Appendix B), which notified them of the nature of the study, and associated risks and benefits, and their rights to refuse

questions, end the interview process, or remove themselves from the study at any time. The informed consent discussion took place immediately prior to the interview process and participants were given the opportunity to ask questions to ensure their comprehension of the informed consent. In addition, participants were asked for their permission to audio record the interview.

Data Collection

Data collection procedures included a semi-structured interview (Appendix C) and a brief survey (Appendix D). Overall, the time burden for each individual participant was approximately an hour and 15 minutes, with the informed consent process accounting for approximately 15 minutes, the interview accounting for approximately 45 minutes, and the survey accounting for approximately 15 minutes.

The interview guide consisted of five sections: (1) history of sexual and reproductive health education, (2) perceptions about contraception, (3) perceptions about abortion, (4) Catholicism, and (5) a conclusion. The participant were warmed up through simple questions about the onset of sexual and reproductive health education in their family and the interview was closed with questions that are more hypothetical and lighter, not bearing heavy emotions. The history of sexual and reproductive health education section included questions about the discussion of sexual and reproductive health during the participant's childhood as well as questions about main information sources (i.e. "How was sexual and reproductive health talked about in your family when you were growing up, if at all?"). The perception of contraception and perception of abortion sections included questions about personal views on contraception and abortion, views about the legality of contraception and abortion, and views about funding of contraception and abortion services (i.e. "When, if at all, would you personally seek an abortion?" followed by "When, if at all, do you think it is acceptable for any person to seek an abortion?"). The Catholicism section included

questions about the stance of the Catholic Church on contraception and abortion as well as questions about the extent to which the participant agrees with these stances (i.e. "To your knowledge, what is the stance of the Catholic Church on contraception?"). Finally, the conclusion included questions about how the participant might talk about contraception and abortion in the future (i.e. "Presuming you will have children, how might you explain birth control and abortion to them?") and provided the opportunity for them to add or discuss anything else. A total of 20 open-ended questions were included in the interview guide. The majority of the questions fell under the perception of contraception and perception of abortion sections of the interview. Probes were utilized to elicit further information or more fully developed responses from participants and to explore new topics that were brought up by the participants themselves.

The survey, the Religious Opposition of Contraception and Abortion survey (ROCA), is modeled after the Ipas Values Clarification and Attitude Transformation and will be used as a tool for quantifying attitudes identified through the interviews that the participant may not have fully explained, with interviews being the main data collection source (Turner and Page, 2008). Surveys were electronically distributed to participants immediately following the interview. All participants were emailed the link to a Survey Monkey survey, through which they completed the survey. The survey contains 15 items, each of which are scored on a Likert scale (1 – Strongly Disagree, 2 – Disagree, 3 – Neither Agree or Disagree, 4 – Agree, and 5 – Strongly Agree). Sample questions include "Women have the right to choose abortion," "I would not personally seek an abortion or encourage my significant other to do so," and "Condoms are only acceptable to prevent disease in monogamous relationships."

The transcription service Temi was used for the transcription of all audio recordings. On a second pass of each transcript, the PI followed along with the transcript, adding any missed words

and making appropriate corrections to the transcript in order to ensure that each transcript was a verbatim representation of the interview. In order to ensure confidentiality, identifying information was redacted from each transcript and participants were given pseudonyms. In addition, the names of friends and family members were replaced with the first letter of their name followed by a series of dashes (ex. E-----). Transcripts and audio files were kept in a password protected file on Emory University's Box platform. Audio files were destroyed immediately following data analysis.

Data Analysis

Audio recordings and interview transcripts were stored directly on the PIs' hard drive under a password protected folder and in a folder on the secure Emory University's Box platform. Hard-copy notes taken during interviews were scanned into the password protected folder and subsequently shredded. To prevent theft and/or loss of data, all hard-copy data, including scanned notes, survey responses, and emails, were immediately deleted following analysis.

The study team conducted data analysis at the Rollins School of Public Health and within the confines of the PIs own home. Before reading each transcript, the PI came up with a set of deductive codes that are relevant to the study's research questions. MaxQDA was used for qualitative analysis of transcripts and a set of inductive codes was identified throughout the coding process. Codes were organized into a codebook with definitions and notes.

In order to improve the quality of the analysis, two additional coders were involved in the formation of the codebook. After the PI reviewed and coded four transcripts, she conferred with the additional coders until there was good intercoder reliability and agreement. In order to assess intercoder reliability and agreement, the PI and additional coders each reviewed the four selected transcripts individually. The coded versions were uploaded into the same MaxQDA project using the teamwork function to assess the degree to which the coders agreed on applicable codes

(Campbell et al., 2013). Coders then came to agreed-upon code definitions, including inclusion and exclusion criteria for each code. Adjustments were made to the codebook and reviewed once again by the two additional coders prior to the analysis of the remaining 17 transcripts.

Following coding, both typological and thematic analysis were used. Thematic analysis was used to identify interconnected codes and provide insight into broader findings (Braun and Clarke, 2006; Hennink et al., 2010). During thematic analysis, the complex coding query in MaxQDA was used to identify intersecting codes and explore possible overarching themes. Once pervasive themes were identified, the PI prioritized the themes that were most relevant to the research question and proceeded with deeper analysis for those themes. Typological analysis was used to create typologies among study participants in respect to their views abortion and hormonal contraception, as well as their ideas about sexual and reproductive health policy (Hennink et al., 2010). Participants' opinions about hormonal contraception and abortion, including morality, religious implications, legality, and funding, were mapped out for each participant. Subsequently, the PI identified distinct and meaningful groups to help explain variation among participants. Typological analysis was appropriate due to its purpose of classifying variations among participants regarding a particular issue: adherence to Roman Catholic dogma about hormonal contraception and abortion (Hennink et al., 2010). Following typological analysis, the PI implemented a member checking process to verify the validity of the typologies and themes proposed in the study (Hennink et al., 2010). To recruit participants from the sample for member checking, the PI emailed all participants and asked them to indicate interest in participating in the member checking process on a first come first serve basis. One member from each proposed typology was included in the member checking process. Members were asked to reflect on the typology in which they were classified and the overall themes and provide any criticism or

additional input to correct or further develop the proposed typologies and themes. After receiving feedback from members, the PI critically reviewed the provided feedback and incorporated any pertinent details that the members felt were missing from the original analysis.

Chapter 4 – Manuscript

Health Services or Sins: A Qualitative Study of American Millennial Catholics' Attitudes toward Hormonal Contraception and Abortion

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Abstract

Catholic dogma indicates that American Millennial Catholics should be opposed to contraception and abortion. However, the current political climate in the US, as well as that in which Millennials were raised, may impact their opinions due to the strong presence of the Women's Health Movement. The purpose of this study is to investigate the attitudes of American Millennial Catholics towards hormonal contraception and abortion, as well as factors that are involved in their opinion formation. Findings from the study show that American Millennial Catholics may be more supportive of liberal sexual and reproductive health legislation than previously evidenced.

Keywords: abortion, contraception, Catholic, millennial, American

Introduction

Contraception and Abortion in the US

In the United States (US), 88.2% of women have used contraception at some point in their lifetime and by the age of 30, 19% of women have obtained an abortion. (Daniels et al., 2013; Jones and Jerman, 2017). In 2015, 58.7% of women who obtained an abortion were in the millennial cohort, ranging from ages 22-38 (Pew Research Center, 2017; Jatlaoui et al., 2018). Health insurance coverage of contraception is nationally mandated per the Patient Protection and Affordable Care Act (ACA), and there are no legal restrictions on contraception (Hemlin, 2017). Funding and access are vastly different for abortion, as the use of federal dollars to fund abortion is illegal, per the Hyde Amendment, and abortion procurement procedure laws are determined on a state level (Boston Women's Health Book Collective, 2011; Hemlin, 2017; Guttmacher Institute, 2019). While hormonal contraception (HC) and abortion are both legal nationally, states have individual laws regarding both HC and abortion procurement procedures. Overall, state policies tend to align with residents' opinions about abortion (Pew Research Center, 2014; Guttmacher Institute, 2017). For example, Colorado, where 59% of residents believe that abortion should be "legal in all or most cases," has no restrictions on abortion, while Mississippi, where 59% of residents believe that abortion should be "illegal in all or most cases," has more restrictive abortion laws (Pew Research Center, 2014; Guttmacher Institute, 2017).

Religious Aspects of Contraception and Abortion

Both abortion and contraception elicit reactions from religious institutions, largely due to theological views about the creation of life. While the US holds the ideal of separation of church and state, "social and political values are codified through the legislative process," meaning that religiously-based ideas about contraception and abortion have the potential to be enacted through

policy (Calfano, 2006). Approximately 22% of millennials identify as Catholic, with millennial Catholics accounting for approximately 4.6% of the American population; this constitutes a noteworthy voting contingent (Bedford, 2012; Pew Research Center, 2017; US Census Bureau, 2017; Feldmann et al., 2016). Thus, their opinions may have implications on sexual and reproductive health policy. Previous research investigates the impact of religion on attitudes surrounding contraception and abortion, but does not do so among this cohort.

Catholic Perception and Utilization. The Roman Catholic Church, hereinafter referred to as "the Church," acts as a religious governing body, asserting that "nothing unnatural should be involved in the process of life and/or its creation" (Pavuk, 2016). Contrary to the Church's opinion on contraception and abortion, recent data indicate that Catholic women in the United States obtain abortions at nearly the same rate as all women and that American Catholic women at risk of unintended pregnancy use contraception at the same rate as all other women (Jerman, Jones, and Onda, 2016; Jones and Dreweke, 2011). 79% of American Catholics believe birth control should be covered by insurance (without indication of whether this insurance should be public or private) (Catholics for Choice, 2016). However, the sample for this study was comprised of only 17% millennials, which is not representative of the actual age distribution of the current Catholic population in the US. In regards to abortion, 60% of American Catholics believe that the decision to have an abortion "can be a morally acceptable position" (Catholics for Choice, 2016). One study of Mexican Catholics found that 90% of participants would support an abortion in the case of rape and/or endangerment of the mother's life (Kung et al., 2018). Further, 51% of participants believed that a women who has an abortion can continue to be a "good Catholic" (Kung et al., 2018).

Study Purpose

This qualitative study investigates American millennial Catholics' opinions about contraception and abortion as well as the factors that are involved in their opinion-formation, and considers the sociopolitical implications of said opinions. This study will provide data to fill the gap in research surrounding millennial Catholic attitudes about abortion and contraception by addressing opinion formation and conceptualization of contraception and abortion in order to understand American millennial Catholic adherence to Roman Catholic doctrine and dogma.

Theoretical Framework

The Theory of Triadic Influence (TTI) and the Moral Foundations Theory (MFT) provide a holistic approach to understanding the ways in which Catholics form opinions about abortion and contraception, as well as how these opinions are transformed and/or solidified over time. TTI provides an overall schema for the ways in which American millennial Catholics' attitudes towards contraception and abortion are created and upheld, while MFT provides insight into the particular importance of Catholic upbringing as an initial moral basis.

According to TTI, levels of causation and streams of influence exist, creating a matrix of various influential sources at different levels of influence (Flay, Snyder, and Petraitis, 2009). Intra-personal influences are particularly important in determining whether American millennial Catholics will utilize hormonal contraceptives or seek abortion services themselves. Interpersonal social influences and cultural-environmental influences have a larger impact on how acceptable American millennial Catholics deem contraception and abortion for others (Flay, Snyder, and Petraitis, 2009).

MFT provides a framework for understanding religion as the moral foundation for interpersonal social influences. According to MFT, there are four basic tenets of moral foundation: (1) we are all born with a "first draft" of the moral mind, (2) this first draft is edited within a

particular culture, (3) intuition and judgement precedes strategic reasoning, meaning that we come to conclusions before we think critically about how we can justify those judgements, and (4) we encounter recurrent social challenges that transform and solidify our morality (Graham et al., 2012). Thus, MFT exists within the interpersonal social influence stream as the way in which the Catholic microcosm informs socio-normative beliefs about contraception and abortion before they are challenged by broader cultural-environmental influences.

Methods

Recruitment and Informed Consent

For the purposes of this qualitative inquiry, a in-depth interviews among 21 American millennial Catholics were used to explore participant opinions on contraception and abortion. All study procedures were approved by Emory University's Institutional Review Board.

The study employed qualitative semi-structured interviews in order to "capture the complexities of human beings and their lives" (Sterk and Elifson, 2004). Interviews were conducted either in person or virtually, via phone calls or Skype. Gatekeepers, snowball sampling, and purposive sampling were used to recruit participants. The Principle Investigator (PI) used her Catholic in-group status to identify Catholic acquaintances and congregation members as gatekeepers, who were asked to inform potential participants about the study and pass along the PI's contact information. Following interviews, the PI asked participants if they knew of anybody who might be interested in participating. Participants were given the PI's contact information to share with other potential participants, thus employing snowball sampling. Finally, the PI posted an ad to Facebook groups that she identified as potentially reaching millennial Catholics. The ad provided details about the study and directed potential subjects to show interest by emailing the PI.

To be eligible, participants must have been born between 1980 and 1996, grown up in and currently live in the United States, and currently identify as Catholic. Potential participants were excluded if they converted to Catholicism. The study aimed to include 30 participants, but only 21 qualifying interviews were ultimately conducted, as saturation was reached before the initial goal of 30 interviews was met.

Informed consent was obtained from all participants prior to data collection. The informed consent discussion took place immediately prior to the interview process and participants were given the opportunity to ask questions to ensure their comprehension of the informed consent. Participants were asked for their permission to audio record the interview.

Data Collection

Data collection included a semi-structured interview. Overall, the time burden for each participant was approximately an hour and 15 minutes. The interview guide consisted of five sections: (1) history of sexual and reproductive health education, (2) perceptions about contraception, (3) perceptions about abortion, (4) Catholicism, and (5) a conclusion.

The transcription service Temi was used for the transcription of all audio recordings. In order to ensure confidentiality, identifying information was redacted from each transcript. Transcripts and audio files were kept in a password protected file on a secure cloud-based platform. Audio files were destroyed following data analysis.

Data Analysis

MaxQDA was used for qualitative analysis of verbatim transcripts. A codebook with definitions and notes was developed to include both deductive and inductive codes (Hennink et al., 2010). Two additional coders were involved in the formation of the codebook. Coders came to agreed-upon code definitions, including inclusion and exclusion criteria for each code based on a

sample of four transcripts. Adjustments were made to the codebook and reviewed once again by the two additional coders prior to the analysis of the remaining 17 transcripts.

Following coding, both comparative and thematic analysis were used. Thematic analysis was used to identify interconnected codes and provide insight into broader findings (Braun and Clarke, 2006). Typological analysis was used to create typologies among study participants (Hennink et al., 2010). Following analysis, member checking was employed within the target population to verify that relevant findings were appropriately depicted (Hennink et al., 2010). Member checking was completed by four individuals, one representing each included typology.

Results

The twenty-one participants included seven men and fourteen women. Participants ranged in age from 23 to 36 and were from a variety of states, including: the District of Columbia, Illinois, Florida, Georgia, Kentucky, Louisiana, Massachusetts, Maine, North Carolina, and Pennsylvania. Overall, participants held differing opinions on the acceptability of hormonal contraception and abortion. Participant opinions can be categorized into four main typologies: (1) Catholic Dogmatic Adherents, (2) Partial Catholic Dogmatic Adherents, (3) Partial Morality Adherents and (4) Non-Adherents. Across these four typologies, three emergent themes are discussed: (1) permissibility of contraception over abortion, (2) opinion formation, and (3) public funding of hormonal contraception and abortion.

Typologies

Typologies were formulated based on two criteria: (1) participants do or do not view abortion and hormonal contraception as a sin having religious implications and (2) participants do or do not view abortion and hormonal contraception as immoral. The distribution of typologies, as well as sample quotes, can be found in Appendix E. Only one group, Catholic Dogmatic

Adherents, view hormonal contraception as sinful and/or immoral. Among the other three typologies, all participants believed that hormonal contraception utilization should be legal, is morally acceptable, and is not sinful. Further, all participants of the other three typologies also believed that abortion should be legal. Thus, the other three typologies are differentiated by their personal views of abortion, rather than their views of hormonal contraception or legislative preferences.

Catholic Dogmatic Adherents. The three participants in this typology, Mark, Matthew, and Faith, are morally and religiously opposed to both contraception and abortion and would prefer that both be illegal in the US, citing Catholic doctrine and dogma directly as the source of their beliefs. These participants believed that hormonal contraception is immoral and sinful if used for pregnancy prevention, but that it is acceptable for other medical uses when prescribed by a physician. When prompted about circumstances in which some might consider abortion an acceptable option, these participants asserted that abortion is almost never acceptable, arguing that a fetus at any gestational stage is equal to the woman in which it is growing. Matthew believed that maternal medical emergencies necessitating an abortion could be morally acceptable. Faith and Mark stated that modern medicine reduces the risk of these complications insofar that resorting to abortion is still immoral and, at best, should be the last resort only in cases of ectopic pregnancy. Faith makes the following argument against abortion:

> Everybody can agree that murder is bad. And so the problem is that people won't acknowledge a fetus as a life. Even if it is impacting somebody else's, we don't get to arbitrarily decide when it's a person. So there's that law, right, where if you kill a pregnant woman, even by accident, you're charged with two counts of murder because killing is illegal and you killed two people. So why do we consider a

> wanted baby a life and not an unwanted one? That just is illogical to me (Faith, white female, 29).

The attitudes and opinions of this group aligned entirely with Catholic dogma, as they agreed with the Church's justification for its opposition to both hormonal contraception and abortion and believe that it is in the best interest of US citizens that US laws uphold these values.

Partial Catholic Dogmatic Adherents. Participants in this typology constitute the largest proportion of the sample. The twelve participants, Anne, Ben, Clare, Eve, Joan, John, Joseph, Helena, Lucy, Luke, Monica, and Teresa, did not take any issue with contraception, but were morally and religiously opposed to abortion. However, they believed that abortion should be legal in the US. Main reasons cited for the legality of abortion include that it is not up to their religious beliefs to dictate the law and that since science cannot definitively tell us when life begins, the US should not ban abortion.

> Following the Catholic dogma on this issue is important to me, so I hold myself to certain standards…. If somebody else believes in their religion… and their religion does not say that abortion is a sin, then I don't think it's appropriate for me to… try to push them into the same standard or belief that I hold, when I know that my belief is from my religion (Eve, mixed race female, age 28).

Moral opposition to abortion that participants of this typology held were embedded in their religious ideology. However, they did not share the Church's opposition to contraception; this exception is further discussed in the emergent theme section: "permissibility of contraception over abortion." While these participants would never procure an abortion under normal circumstances and would be morally conflicted in the case of rape or maternal danger, they believed others should have the liberty to choose for themselves. However, all of these participants believe that there

should be legal restrictions surrounding abortion insofar that women cannot have an abortion if the baby would be viable outside of the mother.

Partial Moral Adherents. The three participants in this typology, Mary, Claudia, and Lucia, were categorized as morally, not religiously, opposed to abortion. These participants asserted that while they do see abortion as immoral, their beliefs are not grounded in Catholicism. The three participants in this typology share the following sentiment:

> My opinion on abortion… doesn't come from my Catholic faith. I've never been like, "Oh yeah, I don't believe in abortion because I'm Catholic." I've never really put them together. To me it just seems morally wrong, but it's not because of what I've learned in Church (Lucia, mixed race female, age 25).

Similarly, Claudia explained that her opinions might have tangential religious connections, but that Catholicism is not the source of her moral opposition:

> What shapes my opinion is my own critical thinking, not my being Catholic. I was raised Catholic, but not influenced by its views about sexuality and reproduction because my mom kind of shielded me from that. The older I get, the more I think "Maybe there is a problem with people having abortions… When is it murder and when is it a more acceptable personal decision?" I'm starting to come to my own conclusions. Maybe that has to do with my relationship with God because I do see him as giver of life… and I do see it as killing them, but Catholicism, specifically, never convinced me that abortion is bad (Claudia, white female, age 24).

The key difference between participants of this typology and those of the previous is that Partial Moral Adherents disassociate their moral opposition of abortion from their Catholic religion. Thus,

they talk about contraception and abortion in the same way that their counterparts in the Partial Catholic Dogmatic Adherent typology do, but do not invoke any religious ideology.

Non-Adherents. The three participants in this category, Adam, Elizabeth, and Margaret, are not morally or religiously opposed to either hormonal contraception or abortion and believe both should be legal. One participant stated the following in regards to abortion:

> I think it's a necessity sometimes. Obviously it's not good, but I don't think it's the worst thing in the world. I think people will have them every day. I wouldn't classify it as morally wrong. There are definitely circumstances when abortion does make the most sense (Adam, white male, age 32).

Adam and Elizabeth stated that there should be legal restrictions surrounding abortion insofar that women cannot have an abortion if the baby would be viable outside of the mother. However, Margaret provided an argument for why there should not be any restrictions on abortion:

> I don't think there should be [restrictions]. I know that some people want to be like "Oh not after there's a heartbeat," but I think that's unacceptable because women can find out they're pregnant after a heartbeat occurs. The other popular idea is a 20-week threshold and I think that that's problematic because, if I remember my statistics correctly, very few pregnancies are ended after 20 weeks, and I'm sure that is not a decision that is made lightly. (Margaret, white female, age 25).

The distinction between this typology and the others is that participants did not invoke moral or religious arguments against abortion and depicted abortion as acceptable in almost all cases.

Emergent Themes

Permissibility of contraception over abortion. There is a notable differential between the permissibility of contraception and that of abortion among study participants. Aside from

participants of the typology "Catholic Dogmatic Adherents," participants stated that contraception should be widely available and accessible. All participants noted the various uses of hormonal contraception (e.g. pregnancy prevention, menstrual regulation, polycystic ovarian syndrome treatment, etc.). Moreover, each of the Catholic Dogmatic Adherents conceded that hormonal contraception is an acceptable medication for health issues unrelated to fertility control. Participants in the other three typologies understand that the Catholic Church still largely opposes the use of contraception, but take no issue in disagreeing with this ideology. Among these participants, the versatility of hormonal contraception is an important characteristic that necessitates wide availability. Nine participants cited hormonal contraception as a basic medical necessity, similarly to antibiotics or heart medicine, because it is "a medication like any other."

While 18 participants had highly liberal views about the permissibility of contraception, this was not the case for abortion. All participants indicated that the Catholic Church is staunchly against abortion, as it is ending a life that God created. As indicated through the aforementioned typologies, 18 participants view abortion as immoral, with 15 participants identifying abortion as a religiously sinful act. However, only 3 participants view contraception as immoral and sinful. When asked about this differential, Eve explained the following:

> The church believes conception begins life and, therefore, an abortion is ending a life because abortion must take place post-conception. So it makes sense to me logically following the Church's own beliefs that an abortion is committing a sin by committing murder. But contraception is actually preventing conception and, therefore, it's really preventing potential sin. Basically, my point is it's I think it's a logical fallacy within the Church that the Church should reconsider (Eve, mixed race female, age 28).

Among the population, Eve is not alone in her view that the Church's opposition to contraception is a "logical fallacy;" seven other participants shared the same sentiment.

Finally, the most agreed upon justification for contraception is abortion aversion. All 18 participants in the three typologies who believe hormonal contraception is acceptable view it as a necessary family planning tool and predetermining factor in avoiding abortion. Anne, who would not personally use hormonal contraception because she is not comfortable with the idea of taking hormones, states the following:

> It was always more of a personal thing for me... It was not "Other people need to be this way because I'm this way," it was more "What are we doing as a culture and society to support women so that abortion doesn't need to happen?" if that makes sense (Anne, white female, age 27).

Participants in this study view contraception as a lesser evil in comparison to abortion. Thus, it follows that they are more readily accepting of contraception as a moral good to avoid committing what they view as an immoral and/or sinful act: abortion. Of course, this is not the case for participants in the Non-Adherent typology, as they do not take issue with either contraception or abortion.

Opinion formation. When asked about influences in opinion formation, all 21 participants cited their family and school as sources of information about contraception and abortion in their early childhood. Four participants did not have any direct conversations with their parents about contraception and abortion; however, three of them had conversations with their siblings and one of them noted overhearing conversations among adults in his family. Overall, mothers were the most common familial source of information about hormonal contraception and abortion among both male and female participants. In addition to family, all participants, regardless whether they

attended Catholic school or secular school, reported receiving some amount of information about contraception and abortion in school. Further, 17 participants identified their Roman Catholic religious connections, including church, Catholic school, and/or Confraternity of Christian Doctrine (CCD), Sunday school courses that Catholic children are enrolled in, as a source of information and ideas surrounding contraception and abortion.

Currently, 18 of the participants feel comfortable with the opinions they've formed and accept the fact that they disagree with the Church regarding some ideas. While this level of comfort varies between typologies, it does not apply to the three participants in the Catholic Dogmatic Adherents. Notably, in regard to how she reconciles her Catholic faith and her favor for pro-choice legislature, one participant asserts the following:

> It's hard for me because this is a faith and Church that I love so much. It's part of who I am and for me to feel at odds with it, sometimes it feels like the Church betrays me and that's something I've really had to sort of sort through as I've gotten older. There's room for growth. You're allowed to disagree with the Church and still identify as Catholic. I came to realize that the Church is imperfect. There are human elements to it. And as humans we are inherently flawed. That is how we were created. We are not God. And so I have the moral obligation and responsibility to figure out and make meaning of things with the guidance and support of the church, but on my own as well. And if that means that I disagree with the Church, then maybe that also means that the Church has some room to grow (Anne, white female, 27).

While the majority of participants in this study (18) disagree with Catholic dogma at present, 14 participants noted that they did not always hold these opinions. Of these 14 participants, 11 were

from the Partial Catholic Dogmatic Adherent typology, two were from the Partial Moral Adherent typology, and one was from the Non-Adherent typology. Each of these 14 participants explained that their opinions about contraception and abortion used to be more in line with those of the Church than they currently are, particularly regarding the legality of abortion. Further, when asked about influences on their opinion transformation, the 14 participants who self-identified as having a change in opinion over time cited inter-personal life experience and college courses as key factors in their opinion transformation.

Public funding of hormonal contraception and abortion. With regard to the acceptability of public funding for contraception and abortion, participants' attitudes ranged even within their typologies. Participants fell within two camps: fiscally conservative or fiscally liberal. However, given the participants' views of societal permissibility of contraception over abortion, it is unsurprising that participants supported public funding of contraception, particularly due to its wide range of uses.

Eleven participants felt contraception should receive government funding that is provided through Medicaid and that it should continue to be mandated for insurance coverage as it is under the ACA. These participants shared the notion that, since contraception has many uses, it should be free and readily available to whoever needs it. Further, four participants cited contraception as preventative healthcare, sharing statements similar to the following:

> I have a bit of a different opinion on um, birth control versus abortion being funded. I think if we focus on prevention, that's always better. So I think we should have public funding for birth control. I think that's where we should focus (Lucy, white female, age 29).

Two participants said that religious waivers should not be allowed for companies who are morally opposed to contraception. These participants also view contraception as a vital tool in "a woman's human right to fertility control" (Margaret, mixed race female, 25).

Eight participants believe that federal funding is acceptable for abortion, including both Medicaid coverage and funding of abortion clinics. All of the 13 participants who did not believe abortion should be publicly funded argue that people should not have to pay for something to which they are morally opposed. Two participants presented arguments against the federal funding of abortion and clinics that provide abortion. Teresa bolstered her opinion by differentiating between private and public sectors:

> I can understand folks who say, "No, this is a moral opposition that I have and I see it as murder all the time. I'm not gonna fund that." Well, if you have a right to abortion because you have a right to privacy and autonomy, that it should be a private decision. If you have the right to privacy, you should pay for it privately. It's not a right to privacy and the public pays for it (Teresa, white female, 36).

12 participants who oppose the public funding of abortion and abortion clinics fundamentally agree that people who morally disagree with abortion should not have to pay for abortion. To further elaborate on how this idea applies to clinics that provide abortions, such as Planned Parenthood, Eve states the following:

> As a Catholic American taxpayer, I do not believe that I should be forced to pay for what I consider to be a sin… I also don't think that it's appropriate for any nonprofit organization that receives government funding to pay for abortions… because money is fungible. So if the government is paying for, I don't know, bedding or linens and that clinic is turning around and paying for abortions, then they're using

> taxpayer dollars to free up other dollars to pay for abortions. (Eve, mixed race female, 28).

Thus, Eve and 12 other participants spoke in favor of the Hyde Amendment and its restrictions on the public funding of abortion and abortion clinics. Joseph presents the following counter-argument in favor the public funding of abortion:

> Ideally, I think there'd be some kind of like public funding for [abortion] where nobody would be turned away from it. I think that comes from my liberation lens because rich people will get it easily, right? So there's the argument that you shouldn't have to pay for something you disagree with, but really that's just hurting the people who are already oppressed. (Joseph, white male, 28).

Further, participants' opinions and reasoning varied independently from their typologies, indicating that there may be other factors influencing the fiscal ideologies of participants.

Discussion

The intent of the present study was to understand American millennial Catholics' current opinions about contraception and abortion, how their opinions were formed, and what socio-political implications their opinions have. Typological analysis revealed four typologies among participants: (1) Catholic Dogmatic Adherents, (2) Partial Catholic Dogmatic Adherents, (3) Partial Morality Adherents and (4) Non-Adherents.

The present study found contraception to be a relatively uncontroversial, but complex, topic for participants to confront. 18 participants viewed contraception as a necessary medication in women's health for both family planning and other women's health issues, while 3 participants viewed contraception as a women's health medication that is immoral for fertility control. Similarly to previous studies, this study found that most participants believe that abortion can be

a morally acceptable decision under certain circumstances (Catholics for Choice, 2016; Kung et al., 2018). This study presents three distinct typologies of Catholics who are in favor of legalization of abortion within certain parameters, as well as a fourth typology that is more closely aligned with Catholic dogma and opposes the legalization of abortion. Despite personal opposition to abortion for themselves, 14 participants believe abortion should be legal in the US, and another three participants believe it should be legal and are not personally opposed. Throughout this study, the idea that the Church upholds dogma that is controversial among its own followers is salient. This in-group controversy is cause for evaluation of societal norms and perceptions of what it means to be Catholic.

While opinions on legalization of hormonal contraception and abortion could be categorized through the four typologies, ideas about public funding varied on an independent level. The majority of participants felt that public funding should be available for contraception, but not for abortion, with the ideological justification for the stance being that while abortion should be a personal decision, people who are religiously and morally opposed to abortion should not have to pay for somebody else to receive one. However, the three participants who felt that contraception is religiously and morally corrupt also felt that they should not have to pay for contraception. Thus, while legality elicits ideas about autonomy among participants, public funding includes ideas about group participation in use of contraception and abortion through funding. Findings suggest that while participants might be tolerant of others committing an act that they religiously or morally disagree with, they are not willing to participate in the funding of such acts, including utilization of contraception and/or abortion. This finding aligns with the theoretical framework, as people assign a different valuation of actions for themselves and for others.

Thematic analysis of opinion formation among study participants finds that participants early conceptions of contraception and abortion were largely influenced by Catholicism through their family and through the Church. However, their opinions were further sculpted by broader environments, such as universities and independent interpersonal relationships, later in life. Thus, findings align with the proposed theoretical basis: the four basic tenants of morality proposed in the MFT exist within the TTI's interpersonal social influence stream as the mechanism through which the Catholic community informs socio-normative beliefs about contraception and abortion before they are challenged by broader cultural-environmental influences (Flay, Snyder, and Petraitis, 2009; Graham et al., 2012).

Strengths and Limitations. The present study includes various strengths including: the PI's ability to recruit participants effectively and understand their cultural language due to her in-group status, the use of a theoretical framework combining the TTI and the MFT, both of which are well documented, and the utilization of member-checking.

This study has a few main limitations. Most notably, the sample was primarily comprised of educated, white, female participants. Additionally, a large portion of American Catholics identify as Hispanic and the study was only able to capture the opinions of two Hispanic women, both of whom identified as mixed race. Finally, the sample was highly education, as all but one of the participants have completed at least a Bachelor's degree. The PI originally intended to include a comparison analysis based on gender, but the unequal gender distribution of participants did not provide enough data for an adequate comparative analysis. Finally, due to the nature of qualitative research, these findings are not generalizable to all American millennial Catholics. While the typologies described provide a basis for understanding American millennial Catholic's adherence

to Roman Catholic dogma regarding hormonal contraception and abortion, it is possible that the typologies do not capture the existing beliefs of all American millennial Catholics.

Implications. The findings of this study include two main implications. First, they provide insight into how the attitudes of American Catholic millennials can, in fact, be in support of both religious ideals and progressive sexual and reproductive health policy. Second, they provide insight into the logic-based justification Catholics, among others, may have for being opposed to pro-choice laws regarding both availability and funding. Together, these insights can provide lawmakers and advocates of both pro-life and pro-choice identities with an understanding of the opinion formation processes of people who have different ideas from themselves.

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Chapter 5 – Public Health Implications

Theoretical Implications

The present study was designed with TTI and MFT in mind, with an emphasis on the idea that being raised Catholic has particular implications regarding morality. Findings from this study supported multiple constructs from TTI including: intra-personal influences, interpersonal influences, and cultural-environmental influences (Flay, Snyder, and Petraitis, 2009). Regarding MFT, findings from this study supported three of the five domains: care/harm, authority/subversion, and sanctity/degradation; the findings did not support the domains of fairness/cheating and loyalty/betrayal (Graham et al., 2012). Further, the findings also supported the four basic tenants of moral foundation proposed by MFT: (1) we are all born with a "first draft" of the moral mind, (2) this first draft is edited within a particular culture, (3) intuition and judgement precedes strategic reasoning, meaning that we come to conclusions before we think critically about how we can justify those judgements, and (4) we encounter recurrent social challenges that transform and solidify our morality (Graham et al., 2012).

After analysis, it became clear through the theme of opinion transformation that MFT does, in fact, exist within the interpersonal stream of TTI. While TTI is an expansive and comprehensive model for understanding influences on personal behavior and opinions, the addition of the MFT to the interpersonal stream helps to further explore the stream in depth and to better understand the intricacy with which religious communities can act as an interpersonal moral foundation. Specifically, MFT provides an explanation for the moral drafts that are created and transformed throughout one's lifetime. Participants in all typologies expressed the way in which their Catholic upbringing influenced their original attitudes towards hormonal contraception and abortion and the subsequent external factors (peer interactions and information from college courses,

specifically sociology and women's gender studies courses) that transformed their attitudes throughout their lifetime. Thus, this study provides an example of the way in which religious upbringing has the power to serve as a foundation for morality that can be further transformed through cultural-environmental, intrapersonal, and other inter-personal influences.

Public Health Implications and Future Directions

The present study has various public health implications, largely regarding policy about access to and funding of hormonal contraception and abortion. The findings of study, while preliminary, provide insight into the influences that impact American millennial Catholics' opinion-formulation about abortion and hormonal contraception. While the literature review of the present study did include a focus on gender-based attitudes towards hormonal contraception and abortion, the study sample did not allow for an adequate gender-based analysis. This limitation is due to the ratio of women to men in the study and the differential in depth of information provided between men and women, with women providing far greater detail than men. Overall, the findings from this particular study sample show that religiosity and secular policy can, in fact, coexist. While Roman Catholic dogma indicates that abortion is immoral and sinful, the notion that some Catholics believe that abortion should be a freedom a choice in the United States, regardless of their personal beliefs, provides a platform for securing legal abortion in the United States.

Public health research largely focuses on identifying risk factors for diseases and health outcomes; however, understanding opinions and the ways in which people are likely to vote or topics they are likely to advocate for can provide critical insight for public health professionals. The current political climate regarding access to women's reproductive healthcare makes this study particularly relevant. As members of Congress and the Supreme Court, as well as some states' General Assemblies look to restrict access to and funding of abortion and hormonal

contraception under the Trump administration, understanding why people would seek to limit access and funding is necessary. Further investigation will allow public health professionals and activists to uncover whether millennial Catholics might be a population that can be used to advocate for reproductive health access within the larger Roman Catholic population, which is generally opposed to unnatural interference in reproduction. Possible directions for future research include the following: (1) a study to assess the efficacy of the typologies proposed in this study, (2) another qualitative study of American millennial Catholics' attitudes towards hormonal contraception and abortion with a greater emphasis on gender-based attitudes, and (3) a large-scale quantitative analysis of American millennial Catholics' opinions about the Hyde Amendment. Public health practitioners could use information gathered from these studies to further advocacy efforts and inform health policy.

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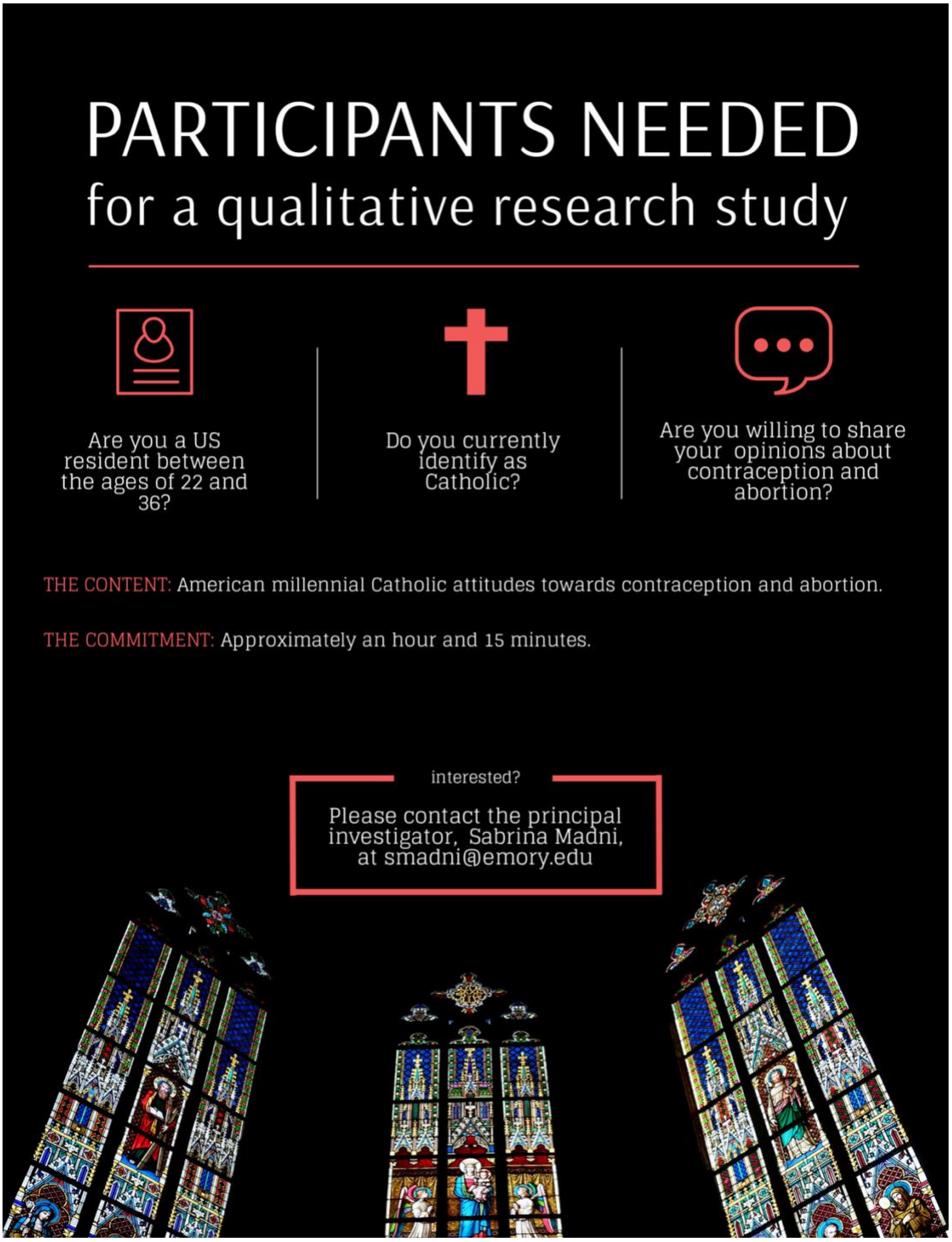
Appendices

Appendix A. Recruitment Flyer



Appendix B. Consent Form

Emory University
Consent to be a Research Subject

Title: Health Services or Sins: A Qualitative Study of American Millennial Catholics' Attitudes towards Contraception and Abortion

Principal Investigator: Sabrina Madni, BA, Behavioral Science and Health Education MPH Candidate

Introduction

You are being asked to be in a research study. This form is designed to tell you everything you need to think about before you decide to consent (agree) to be in the study or not to be in the study. **It is entirely your choice. If you decide to take part, you can change your mind later on and withdraw from the research study. You can skip any questions that you do not wish to answer.**

Before making your decision:

- Please carefully read this form or have it read to you
- Please ask questions about anything that is not clear

You can take a copy of this consent form, to keep. Feel free to take your time thinking about whether you would like to participate. By signing this form you will not give up any legal rights.

Study Overview

The purpose of this study is to describe the opinions about contraception and abortion among American millennial Catholics and to describe the factors that shape how American millennial Catholics view the interface of religion and sexual and reproductive health policy.

Procedures

This study includes both an interview and a brief survey. The interview will take approximately 60 minutes and will cover the following topics: (1) history of sexual and reproductive health education, (2) personal beliefs about contraception, (3) personal beliefs about abortion, (4) health policy, and (5) Catholicism.

Risks and Discomforts

While this study does not pose any risks of injury, bodily harm, employability, financial standing, or criminal/legal status, there is a potential for some risk in the case of loss of privacy or breach of confidentiality.

Benefits

This study is not designed to benefit you directly. This study is designed to learn more about American millennial Catholic attitudes towards contraception and abortion. The study results may be used to help others in the future.

Confidentiality

Certain offices and people other than the researchers may look at study records. Government agencies and Emory employees overseeing proper study conduct may look at your study records. These offices include the Office for Human Research Protections, the Emory Institutional Review Board, the Emory Office of Research Compliance. Emory will keep any

research records we create private to the extent we are required to do so by law. A study number and/or pseudonym, rather than your name, will be used on study records wherever possible. Your name and other facts that might point to you will not appear when we present this study or publish its results.
Study records can be opened by court order. They may also be produced in response to a subpoena or a request for production of documents.

Voluntary Participation and Withdrawal from the Study

You have the right to leave a study at any time without penalty. You may refuse to answer any questions that you do not wish to answer. Should you choose to withdrawal from the study, you will be given then option to allow for your responses up until your point of withdrawal to be used in the study or to have them destroyed immediately.

Contact Information

Contact Sabrina Madni at (707) 785-6280

- if you have any questions about this study or your part in it or
- if you have questions, concerns or complaints about the research

Contact the Emory Institutional Review Board at 404-712-0720 or 877-503-9797 or irb@emory.edu:

- if you have questions about your rights as a research participant.
- if you have questions, concerns or complaints about the research.
- You may also let the IRB know about your experience as a research participant through our Research Participant Survey at http://www.surveymonkey.com/s/6ZDMW75.

Consent

Do you agree to take part in the study? Please click: Yes No

Appendix C. Interview Guide

I. Introduction

Hi, my name is Sabrina Madni and I am a second year student in the Rollins School of Public Health at Emory University studying Behavioral Science and Health Education. My interests lie in sexual and reproductive health. I first wanted to thank you for speaking with me and participating in my thesis research. The purpose of this study is to explore how American millennial Catholics view sexual and reproductive health practices. We will cover topics of abortion and contraception, so please feel free to pause at any time if you feel uncomfortable. I understand that these topics can be heavy and that they may bring personal experiences to mind.

The information you share during this interview will only be used for the purpose of this study. Please keep in mind that your name and any identifying information that you might disclose will be removed from the final product of this study. For the purposes of the study, you will be provided with a pseudonym. The interview should take no longer than 30 minutes and I would like to remind you that you are free to stop the interview at any point. Furthermore, if you are uncomfortable with a question, you are free to decline. To ensure that I am able to engage fully with you throughout our time together, I would like to take an audio recording. Do I have your permission to do so?

II. History of Sexual and Reproductive Health Education

1. How was sexual and reproductive health talked about in your family when you were growing up, if at all?
    a. When did these conversations start?
    b. Who, specifically, did you have them with?
        i. Parents?
        ii. Siblings?
2. Where did you learn about contraception from?
    a. Do you remember around what age you learned about it?
    b. Who, specifically, told you about them or talked about them around you?
        i. Parents?
        ii. Siblings?
        iii. Peers?
        iv. School?
    c. What were you told about it?
    d. If you remember, what did you think about it at the time?
3. Where did you learn about abortion from?
    a. Do you remember around what age you learned about it?
    b. Who, specifically, told you about them or talked about them around you?
        i. Parents?
        ii. Siblings?
        iii. Peers?
        iv. School?

c. What were you told about it?
d. If you remember, what did you think about it at the time?

III. Perceptions about Contraception

1. How would you explain birth control to somebody who didn't know what it was?
2. When, if at all, would you personally use birth control?
    a. *Male participants*: When, if at all, would you encourage your significant other to use birth control?
3. When, if at all, do you think it is acceptable for any person to use birth control?
    a. *If this is different from 2:* Why do you think you have a different standard for yourself and for other people?
    b. Do you think there is a moral difference between using birth control in wedlock and using it out of wedlock?
        i. Why do you/don't you think there is a moral difference?
4. How has your opinion on birth control changed between childhood and today?
    a. What people impacted this?
    b. What institutions impacted this?
        i. Church?
        ii. School?
5. How do you think birth control should be paid for?
    a. Insurance? Out of Pocket?

IV. Perceptions about Abortion

1. How would you explain abortion to somebody who didn't know what it was?
2. When, if at all, would you personally seek an abortion?
    a. *Male participants*: When, if at all, would you encourage your significant other to seek an abortion?
3. When, if at all, do you think it is acceptable for any person to seek an abortion?
    a. *If this is different from 2:* Why do you think you have a different standard for yourself and for other people?
    b. What restrictions, if any, do you think there should be on abortion? Why?
4. How has your opinion on abortion changed between childhood and today?
    a. What people impacted this?
    b. What institutions impacted this?
        i. Church?
        ii. School?
5. How do you think abortion should be paid for? Why?
    a. Insurance? Out of Pocket?
    b. What is your stance on the funding of clinics that provide abortions through tax dollars?

V. Catholicism

6. Where did/do you learn Catholic teachings?

    a. How regularly do you attend church?
7. To your knowledge, what is the stance of the Catholic church on birth control?
    a. *If against it:* Why is that?
    b. Where were you taught this information?
    c. How much do you agree with this?
8. To your knowledge, what is the stance of the Catholic church on abortion?
    a. *If against it:* Why is that?
    b. Where were you taught this information?
    c. How much do you agree with this?
9. How much impact do you think religious beliefs should have on laws?
    a. How do you separate your religious beliefs from what you believe the law should be?

V. Conclusion

1. Presuming you will have children, how might you explain birth control and abortion to them?
    a. How will Catholicism shape this explanation?
2. How important to you is sexual and reproductive health in election platforms to you?
    a. What might you look for in a candidate in terms of views on availability of birth control?
    b. What about funding of birth control?
    c. What might you look for in a candidate in terms of views on availability of abortion?
    d. What about funding of abortion?
3. Is there anything else you would like to add or discuss?

Appendix D. Religious Opposition to Contraception and Abortion Survey

Purpose: The purpose of this study is to explore how American millennial Catholics view sexual and reproductive health practices including contraception and abortion.

The information you share in this survey will only be used for the purpose of this study. Please keep in mind that your name and any identifying information that you might disclose will be removed from the final product of this study.

For each of the questions below, circle the response that best characterizes how you feel about the statement, where: 1 – Strongly Disagree, 2 – Disagree, 3 – Neither Agree Nor Disagree, 4 – Agree, and 5 – Strongly Agree.

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
1. Religion plays a role in my beliefs about reproduction.	1	2	3	4	5
2. It is immoral to have an abortion.	1	2	3	4	5
3. Federal tax dollars should fund contraception.	1	2	3	4	5
4. Terminating a pregnancy violates a fetus's human rights.	1	2	3	4	5
5. Religion-based reasoning should not influence policies.	1	2	3	4	5
6. Contraception is more acceptable than abortion.	1	2	3	4	5
7. It is acceptable to have an abortion if pregnancy endangers the mother.	1	2	3	4	5
8. I would not personally seek an abortion or encourage my significant other to do so.	1	2	3	4	5
9. Women have the right to choose abortion under any circumstance.	1	2	3	4	5

10. Contraception is only acceptable for family planning purposes in wedlock.	1	2	3	4	5
11. Increasing the availability of contraception would decrease the prevalence of abortions.	1	2	3	4	5
12. Contraception is anti-life because it prevents possible humans from being conceived.	1	2	3	4	5
13. Abortion should be legal in cases of rape and incest.	1	2	3	4	5
14. Abortion is not murder.	1	2	3	4	5
15. Federal tax dollars should fund abortion.	1	2	3	4	5

16. Gender _____

17. Age _____

18. Race _____

19. Education
    a. High school
    b. Some college
    c. Bachelors
    d. Masters or beyond

Thank you for taking the time to complete this survey!

Appendix C. Typologies

Typology	Frequency (total)	Frequency (men)	Frequency (women)	Sample Quote
Catholic Dogmatic Adherents	3	2	1	"*Everybody can agree that murder is bad. And so the problem is that people won't acknowledge a fetus as a life. Even if it is impacting somebody else's, we don't get to arbitrarily decide when it's a person."*
Partial Catholic Dogmatic Adherents	12	4	8	*"Following the Catholic dogma on this issue is important to me, so I hold myself to certain standards…. If somebody else believes in their religion… and their religion does not say that abortion is a sin, then I don't think it's appropriate for me to… try to push them into the same standard or belief that I hold, when I know that my belief is from my religion"*
Partial Moral Adherent	3	0	3	*"My opinion on abortion… doesn't come from my Catholic faith. I've never been like, "Oh yeah, I don't believe in abortion because I'm Catholic." I've never really put them together. To me it just seems morally wrong, but it's not because of what I've learned in Church"*
Non-Adherent	3	1	2	*"I think it's a necessity sometimes. Obviously it's not good, but I don't think it's the worst thing in the world. I think people will have them every day. I wouldn't classify it as morally wrong. There are definitely circumstances when abortion does make the most sense"*